DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-01

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 3 — 0 2

2. STATE: West Virgini

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
February 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 USC 1396r-4(g) & 42 CFR 447.272

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $5,620,000*
b. FFY 2004 $ 7.5 million*

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4-19A
Pages 24d and 24e

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
This plan amendment amends the payment methodology for state-owned ~~and non-st~~ government-owned hospitals by providing for payments within the upper payment limits as set forth in 42 CFR 447.272.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Nancy V. Atkins

13. TYPED NAME:
Nancy V. Atkins, MSN, RNC, NP

14. TITLE:
Commissioner

15. DATE SUBMITTED:

16. RETURN TO:
Nancy V. Atkins, MSN, RNC, NP
Commissioner
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301-3706

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
MAR 28 2003

18. DATE APPROVED:
3/24/2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
FEB - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
Brian for Smith

21. TYPED NAME:
Charlene Brown

22. TITLE:
Deputy Director, CMSO

23. REMARKS: State will Reduce estimate to remove county hosp.'s from estimate.

2. a. Outpatient Hospital Services

(1) Reimbursement is based on a fee for service and may not exceed the amount established for any qualified provider for the same service. Laboratory and x-ray services may not exceed the amount established by Medicare for the procedures.

(2) Other services specific to hospitals; i.e., emergency room, outpatient surgery, cast room, may not exceed the established Medicare upper limits based on reasonable cost.

b. Special Payment to Public Safety Net Hospitals

Provides enhanced payments to qualified Public Safety Net Hospitals beginning in SFY 2003. The enhanced payments will be made as described below:

(1) Specific Criteria for Hospital Participation:

(a) Must be a West Virginia licensed outpatient acute care hospital;
(b) Must be enrolled as a West Virginia Medicaid provider;
(c) Must be classified as a state-owned or operated hospital as determined by the Bureau for Medical Services.

(2) The amount of the supplemental payment made to each state-owned or operated public hospital is determined by:

(a) Calculating for each hospital the reasonable estimate of the amount that would be paid for outpatient services provided to Medicaid eligibles under the Medicare program and the amount otherwise actually paid for the services by the Medicaid program. The reasonable estimate of the amount that would be paid under Medicare payment principles is calculated using a hospital specific outpatient Medicare payment to charge ratio which is derived using the most recently settled Medicare cost report (2552) available for each hospital at the beginning of the state fiscal year for which calculations are made. The hospital specific outpatient Medicare payment to charge ratio is then multiplied by each hospitals Medicaid's outpatient charges to calculate each hospital's portion of the upper limit payment ceiling. The aggregate upper limit payment ceiling is then arrived at by summing up each specific hospital's calculated amount. For upper limit purposes, all hospitals are grouped in accordance with the state owned or operated class of hospitals as defined in 42 CFR 447.321 as amended.

(b) Dividing the difference determined in 2.a. above for the hospital by the aggregate difference for all such hospitals; and

(c) Multiplying the proportion determined in 2.b. above by the aggregate upper payment limit amount for all such hospitals, as determined in accordance with 42 CFR § 447.321 less all payments made to such hospitals other than under this section. This amount will be adjusted for TPL, beneficiary co-payments and professional physician fees.

(3) Supplemental payments made under this section will be made on a quarterly basis to state owned facilities subject to final settlement.

(4) A payment made to a hospital under this provision when combined with other payments made under the state plan shall not exceed the limit specified in 42 CFR § 447.321 or the limit specified at 42 U.S.C. § 1396r-4(g). Any payment otherwise payable to hospitals under this section but for this paragraph shall be distributed to other hospitals in accordance with proportions determined under b.2. above.

2. c. Federally Qualified Health Center and Rural Health Clinic Services

As defined in the Social Security Act at Sections 1905(1)(1) and 1905(1)(2) of the Act (42 U.S.C 1396d (1) (1) and (1) (2).

The Benefits Improvement and Protection Act (BIPA) of 2000 authorizes the following:

1. Fiscal Year 2001. Beginning with fiscal year 2001 with respect to services furnished on or after January 1, 2001, during fiscal year (hereinafter fiscal year will be the state fiscal year, July 1 to June 30, unless otherwise specified) 2001, Prospective Payment System (PPS) payments will be an amount (calculated on a per visit basis) equal to 100 percent of the average of the costs of the clinic/center during their fiscal years 1999 and 2000 which are reasonable and related the cost of furnishing services or based on such other test of reasonableness as the Secretary prescribes under section 1833(a)(3) or in the case of services to which such regulations do not apply the same methodology used under section 1833(a)(3) adjusted to take into account any increase or decrease in the scope of services furnished by the clinic/center during fiscal year 2001. The methodology to establish a provider's PPS baseline per visit amount will be the single per visit cost amount derived as the average cost per visit from combining the provider's costs for both fiscal years 1999 and 2000 and dividing those costs by the provider's visits for the same periods.

1a. Fiscal Year 2002 and Succeeding Fiscal Years. For services furnished after fiscal year 2002 and succeeding fiscal years, payment for services shall be equal to the amount calculated for such services for the preceding fiscal year increased by the percentage increase in the Medicare Economic Index (MEI) applicable to primary care services for that fiscal year adjusted to take into account any increase or decrease in the scope of such services furnished by the clinic/center during that fiscal year.

Inpatient Hospital Services

L. Special Payment to Public Safety Net Hospitals

Provides enhanced payments to qualified Public Safety Net Hospitals beginning in SFY 2003. The enhanced payments will be made as described below:

1. Specific Criteria for Hospital Participation:

   a. Must be a West Virginia licensed inpatient acute care hospital;
   b. Must be enrolled as a West Virginia Medicaid provider;
   c. Must be a participant in the West Virginia Medicaid's PPS;
   d. Must be classified as a state-owned or operated hospital as determined by the Bureau for Medical Services.

2. The amount of the supplemental payment made to each state-owned or operated hospital is determined by:

   a. Calculating for each hospital the reasonable estimate of the amount that would be paid for inpatient services provided to Medicaid eligibles under the Medicare program and the amount otherwise actually paid for the services by the Medicaid program. The reasonable estimate of the amount that would be paid under Medicare payment principles is calculated using a hospital specific inpatient Medicare payment to charge ratio which is derived using the most recently settled Medicare cost report (2552) available for each hospital at the beginning of the state fiscal year for which calculations are made. The hospital specific inpatient Medicare payment to charge ratio is then multiplied by each hospitals Medicaid's inpatient charges to calculate each hospital's portion of the upper limit payment ceiling. The aggregate upper limit payment ceiling is then arrived at by summing up each specific hospital's calculated amount. For upper limit purposes, all hospitals are grouped in accordance with the state owned or operated public class of hospitals as defined in 42CFR 447.272 as amended.

   b. Dividing the difference determined in 2.a. above for the hospital by the aggregate difference for all such hospitals; and

   c. Multiplying the proportion determined in 2.b. above by the aggregate upper payment limit amount for all such hospitals, as determined in accordance with 42 CFR § 447.272 less all payments made to such hospitals other than under this section.

3. Supplemental payments made under this section will be made on a quarterly basis subject to final settlement.

4. A payment made to a hospital under this provision when combined with other payments made under the state plan shall not exceed the limit specified in 42 CFR § 447.271 or the limit specified at 42 U.S.C. § 1396r-4(g). Any payment otherwise payable to hospitals under this section but for this paragraph shall be distributed to other hospitals in accordance with proportions determined under L.2. above.